Chapter III

SUMMARY OF THE *INITIAL REPORT OF THE MBC ENFORCEMENT PROGRAM MONITOR*

On November 1, 2004, the Monitor team released its initial findings and recommendations in the *Initial Report of the Medical Board Enforcement Program Monitor*.[13] The 294-page report is available on the Medical Board's Web site at www.medbd.ca.gov and on the Web site of the University of San Diego School of Law's Center for Public Interest Law at www.cpil.org.

A. Principal Findings of the *Initial Report*

In the *Initial Report*, the Monitor presented a number of major findings about the Medical Board's enforcement and diversion programs. These findings highlight significant limitations on the Board's ability to protect the public through its enforcement and diversion programs. Some of them are within the Medical Board's control; others are beyond its control. For summary purposes, these findings may be grouped and described as follows:

1. The structure of the Board's enforcement program is inefficient and outdated. The current structure of MBC's enforcement program and process used to handle serious complaints against physicians — which places Medical Board investigators and HQE's specialized prosecutors in separate agencies — is fragmented, inefficient, and outdated. Currently, a Medical Board investigator with little or no legal guidance works up a case and then "hands it off" to a deputy attorney general (DAG) who has had no involvement in the planning or direction of the investigation and then has no investigative assistance thereafter. Most other similar law enforcement agencies on the federal, state, and local levels use a "vertical prosecution" model in which (1) investigators and prosecutors work for the same entity; (2) an investigator/prosecutor team is assigned to each case as soon as it warrants formal investigation; and (3) that team handles the case as a team through its

[13] Fellmeth and Papageorge, *Initial Report of the Medical Board Enforcement Program Monitor* (Nov. 1, 2004) (hereinafter "*Initial Report*").

ultimate conclusion, whether that conclusion is a quick closure for lack of evidence or a presentation to the California Supreme Court on appeal. The vertical prosecution model is a team approach that encourages early coordination — often leading to faster decisions, filings, and results — and eliminates redundant reviews and conflicting efforts by investigators, attorneys, and supervisors.[14]

The Monitor noted other structural infirmities in MBC's enforcement program. Specifically, existing venue statutes that govern the location of the administrative hearing and the court challenge to any resulting MBC disciplinary action are unnecessarily expensive to the Board and its licensees, and are inconvenient and inefficient for those who must participate in Medical Board disciplinary proceedings (including prosecutors and administrative law judges).

2. The Medical Board has woefully inadequate resources for its important enforcement function. For over a decade, the Medical Board has been starved for budgetary resources: Physicians' license fees have not been increased since January 1994, notwithstanding a 28% increase in the California Consumer Price Index during those eleven years.[15] In addition, the Board has been starved for human resources: Since 2001, MBC has lost 29 enforcement program positions (a 16.2% reduction) and the Attorney General's Office has lost six HQE DAGs (a 15% reduction) due to the state's hiring freeze[16] — contributing greatly to the chronic case processing delays.[17]

3. MBC case processing times are unacceptably high. The Medical Board's enforcement process simply takes too long to protect the public. This delay in justice — which is significant in the context of the irreparable harm threatened by an incompetent or impaired physician — has many causes. For example, although state law requires the Board to set a goal of completing an investigation within 180 days from receipt of the complaint,[18] the Monitor found that an average of

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[14] For a complete discussion of this issue, *see id*. at Chapters VII (Field Investigations: District Offices) and IX (Prosecutions: Health Quality Enforcement Section).

[15] *Id*. at 64–65.

[16] Due to unprecedented deficits in the state's general fund, then-Governor Gray Davis imposed a statewide hiring freeze on October 23, 2001. Governor Arnold Schwarzenegger continued the hiring freeze shortly after he was sworn in on November 17, 2003, and allowed it to end effective June 30, 2004. Despite the facts that (1) MBC is a "special fund" agency funded solely by licensing fees paid by physicians; (2) MBC receives no money from the general fund; (3) any salary savings to the Medical Board by virtue of the hiring freeze does not assist the general fund deficit in any way whatsoever; and (4) in fact, Business and Professions Code section 2445 prohibits the transfer of any MBC funds to the general fund, the hiring freeze (including its subsequent automatic loss of vacant positions) was imposed on MBC as if it were funded solely by the general fund. *Id*. at 65–67.

[17] *Id*.

[18] Business and Professions Code section 2319(a), enacted in 1990, requires MBC to establish a goal that "an average of no more than six months will elapse from the receipt of complaint [sic] to the completion of an investigation." Section 2319(b) sets a one-year goal for the completion of investigations in cases involving "complex medical or fraud issues or complex business or financial arrangements."

340 days elapses from MBC's receipt of a serious quality of care complaint to the conclusion of the investigation. One reason is that many physicians refuse to honor lawful MBC requests for medical records of complaining patients or otherwise delay in producing requested records, and neither MBC investigators nor HQE prosecutors aggressively enforced existing laws governing medical records procurement. Similar delays plague other steps in the long enforcement process, including initial complaint processing,[19] securing physician interviews during an investigation,[20] and the procurement of an expert opinion necessary to prove a violation.[21] Overall, there is an unacceptable 2.63-year average time lag between the filing of a serious complaint and a conclusion or decision by the Medical Board, and an average of 3.75 years elapses if superior court review of a Medical Board disciplinary decision is involved.[22] A regulatory result which takes three or four years is a denial of substantive justice for all concerned.

4. Failure to exchange expert opinion delays and impedes the enforcement process. The MBC/HQE enforcement process is routinely delayed and frustrated because, whereas MBC requires its expert witnesses (physicians) to put their expert opinions in writing and shares them with the other side, defense counsel do not require their medical experts to put their expert opinions in writing and exchange them with MBC or HQE prior to the administrative hearing. This practice stifles the settlement process and often disadvantages the DAG at the hearing. If each side had access to the other side's expert opinions (as occurs in civil medical malpractice cases), it is likely that fewer hearings would be required and more settlements would be reached — saving time and money, and resolving the matter more quickly for the benefit of both the physician and the public.[23]

5. Many of MBC's most important detection mechanisms are failing it. Despite the extensive "mandatory reporting scheme" set forth in Business and Professions Code section 800 *et seq*., the Medical Board is not receiving information to which it is statutorily entitled about civil judgments, settlements, and arbitration awards against physicians, criminal convictions against physicians, or hospital disciplinary (peer review) actions against physicians as required by law — information that enables MBC to detect possible physician wrongdoing, investigate, and take

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[19] *Initial Report*, *supra* note 13, at 99 (average overall CCU complaint processing time was 79 days in 2003–04), 100 (average CCU complaint processing time for quality of care complaints was 140 days in 2003–04).

[20] *Id*. at 142 (average time between MBC's request for a physician interview and either completion of the interview or refusal by the physician to be interviewed was 60 days in 2003–04).

[21] *Id*. at 160 (average time between MBC delivery of medical records to an expert witness and expert's return of an expert opinion was 69 days in 2003–04).

[22] *Id*. at 63–64 and Ex. V-D.

[23] *Id*. at 160–61.

disciplinary action as appropriate.[24] Further, physicians themselves routinely conceal information about their own misconduct from the Board through the insertion of "regulatory gag clauses" — provisions that prohibit an injured plaintiff from complaining to or cooperating with the Medical Board — into civil malpractice settlement agreements.[25]

6. The Medical Board's public disclosure policy is insufficient. The Board's complex public disclosure statutes and regulations — which have evolved in patchwork-quilt style over the past decade — do not allow the Board to disclose sufficient information about physician conduct and history to enable patients to make informed decisions about their physicians.[26]

7. The Board's Diversion Program — charged with monitoring substance-abusing physicians — is significantly flawed: Its most important monitoring mechanisms are failing, it is chronically understaffed, and it exposes patients to unacceptable risks posed by physicians who abuse drugs and alcohol. In a series of audits of the Diversion Program beginning in the early 1980s, the Auditor General's Office found that participants in the Program are not drug-tested as often as they should be and are not terminated from the Program even after repeated violations; additionally, no standards exist to guide the functioning of "worksite monitors" who purportedly oversee Program participants when they practice medicine. Overall, the Auditor General found that the Program — due in part to severe understaffing — generally fails to adequately monitor substance-abusing physicians while permitting them to practice medicine, and that the Medical Board has inadequately supervised the Program. Despite repeated findings by the Auditor General and repeated promises by the Board to address the problems identified, the *Initial Report* documents that all of these deficiencies continue to exist today — almost 25 years later.[27]

B. Recommendations in the *Initial Report*

In the *Initial Report*, the Monitor presented a total of 65 recommendations for improvement to the Medical Board's enforcement program. Some of these recommendations require legislative and structural change; others may be addressed internally by the Board through regulatory, administrative, or procedural change. The Monitor's major recommendations may be grouped into seven categories for purposes of summary:

1. Structural reform of the enforcement program. The Monitor recommended adoption of the vertical prosecution model for improved enforcement efficiency and effectiveness. The

[24] *Id*. at 109–12.

[25] *Id*. at 112–14.

[26] *Id*. at 212–23.

[27] *Id*. at 254–85.

Monitor proposed the transfer of the Medical Board's investigators from the jurisdiction of the politically appointed Board to the Attorney General's Office — and specifically into HQE — so investigators and prosecutors could work together in the team approach of vertical prosecution that is widely used at other law enforcement agencies. This structural proposal would improve the efficiency of investigations and prosecutions, assist the Medical Board in addressing its chronic inability to recruit and retain experienced investigators, and address a perception on the part of the public that investigators "work for a board dominated by doctors" and have no incentive to protect the public from those doctors.[28]

The Monitor also recommended amendments to statutory provisions governing the venue of MBC administrative hearings and judicial challenges to Medical Board disciplinary decisions.

2. Ensuring adequate MBC enforcement resources. The Monitor called for an appropriate increase in the statutory ceiling on physician licensing fees from $610 biennially (in 2003–04, physicians actually paid $300 per year in licensing fees, while lawyers paid $390 and podiatrists paid $450 per year) to at least $800 biennially (that is, from $300 per year to $400 per year). These added resources would enable the Board to reinstate investigator/prosecutor positions lost as a result of the hiring freeze, implement vertical prosecution, reform and sufficiently staff the Diversion Program, reinstate critical programs it had to abandon during the eleven-year financial drought, and maintain an adequate reserve fund as required by state law.[29]

3. Reduction of investigative delays. The Monitor recommended that MBC and HQE develop and consistently apply new policies to enforce existing medical records procurement laws and to end other frequent delays in obtaining physician interviews and expert witness testimony.[30]

4. Timely exchange of expert opinions. The *Initial Report* recommended that the Medical Practice Act be amended to provide that any party wishing to rely on expert testimony must reduce that expert testimony to writing and provide it to the other party well in advance of the administrative hearing. This procedural change would promote earlier and more informed case evaluation and negotiations, leading to quicker and more frequent settlements to the benefit of physicians and the public alike.[31]

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[28] *Id*. at 129–40, 149 (Recommendation #22), 170–71, 176 (Recommendation #33).

[29] *Id*. at 64–67, 72 (Recommendations #1 and #2).

[30] *Id*. at 100–01, 117 (Recommendation #7), 140–41, 149 (Recommendation #23), 171–72, 176 (Recommendation #34).

[31] *Id*. at 160–62 (Recommendation #30).

5. Improved detection of physician misconduct. The Monitor proposed a number of new reporting requirements to ensure that the Medical Board is informed of events indicating potential physician incompetence or impairment. To improve required reporting by court clerks of criminal convictions and civil judgments, the Monitor suggested that the Department of Consumer Affairs initiate a comprehensive educational program for courtroom clerks on behalf of all of its agencies with reporting requirements. In addition, the *Initial Report* (1) called on the Board to expedite and complete a study of the hospital peer review process that was mandated in a 2001 law (but never completed due to budgetary constraints), so that loopholes and problems in peer review reporting to MBC can be identified and closed; (2) suggested the imposition of penalties on insurance companies that fail to report medical malpractice payouts as required by law; and (3) urged the Legislature to statutorily ban so-called "regulatory gag clauses" contained in civil settlement agreements.[32]

6. Enhanced public disclosure. The Monitor recommended that the statutes governing public disclosure be streamlined to eliminate inconsistencies, redundancies, and drafting errors. The Monitor also called for the required public disclosure of (1) medical malpractice settlements over $30,000; (2) misdemeanor criminal convictions against physicians that are "substantially related" to the duties, qualifications, and functions of a physician; (3) significant terms and conditions of probation imposed by MBC; and (4) the resignation or surrender of hospital privileges after a hospital has notified a physician of an impending investigation.[33]

7. Diversion Program reform. The Monitor called on the Medical Board to reevaluate whether the "diversion" concept is feasible, possible, and protective of the public interest. If the concept is deemed viable, the Monitor recommended that MBC's Division of Medical Quality spearhead a comprehensive overhaul of the Diversion Program to correct longstanding deficiencies that have limited the Program's effectiveness in assisting participant recovery and in protecting the public. This overhaul must include not only additional staffing for the Program but also adoption and enforcement of standards and criteria to which both Program participants and staff are consistently held. Additionally, the Monitor recommended that MBC more fully integrate and incorporate Diversion Program management into overall Board and enforcement program management, and ensure that the *Diversion Program Manual* — which is so outdated that it has become obsolete — is completely rewritten. Finally, the Monitor recommended that the Diversion Program — if it is continued and once its problems are addressed — be required to undergo a full performance audit by the Bureau of State Audits (formerly the Auditor General).[34]

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[32] *Id*. at 109–14, 118–20 (Recommendations #12–#19).

[33] *Id*. at 212–24 (Recommendations #48–#52).

[34] *Id*. at 254–89 (Recommendations #56–#65).